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Policy Name Indiana Appeals Policy for CHC and CHC of Illinois in Indiana Customers Version 6.1		Policy Number SQ - 2
Line of Business: Cigna Behavioral Health, Healthcare East and West, Cigna Voluntary, Cigna Global Health Benefits* (* Cigna Global Medical Necessity Appeals for services provided outside the U.S. and all Administrative Appeals)		
Initial Effective Date: 12/2010	Last Revised Dates: 12/2010; 01/2012; 03/2012; 12/2012; 05/2013; 01/2014; 05/2014; 01/2015; 06/2015; 10/2015; 07/2016; 01/2017; 09/2017; 09/2018; 01/2019	National Policy Committee Approval

Purpose:

This Indiana Appeals Policy applies to all Customers in Cigna medical and dental products. The purpose of this policy is to outline the requirements of the Customer appeal process for administrative benefit coverage denials and medical necessity denials (which include denials based upon experimental/investigational/unproven and similar exclusions) of requested benefits. This policy outlines how Cigna complies with: (a) the current standards for appeals processing as set forth by the NCQA and URAC accrediting organizations, as applicable; (b) the Federal Department of Labor's ERISA regulatory requirements, including informing the Customer or his/her representative of the right to pursue remedies in court pursuant to Section 502(a) of ERISA; (c) the Interim Final Rules relating to internal claims and appeals and external review processes under the Affordable Care Act ("ACA") and (d) Indiana regulatory requirements for appeal processing. State-specific Appeals Policies have been drafted to comply with state regulatory appeal requirements and apply to non-ASO Customers and, in some states, to ASO non-ERISA Customers in states whose appeal processing requirements differ from Cigna's National Appeals Policy for Customers.

Policy Statement:

Who Can Appeal

A Customer can request, orally or in writing, an appeal of any adverse benefit determination, including both initial medical necessity and claim payment-related issues, that the Customer believes is not adequately addressed or resolved by Customer Service. The internal appeal process is provided at no cost to the Customer or to the Customer's authorized representative. However, the Customer is only allowed one set of internal appeals per issue.

When a party initiates an appeal on behalf of the Customer, the Customer must be aware of this representation and have authorized the representative to appeal on his/her behalf. However, for Expedited/Urgent appeals, a Provider or facility provider with knowledge of the Customer's condition is always deemed to act as the Customer's representative. For all other appeals, if the Customer does not authorize the representative to appeal on his/her behalf, the Customer can reject the representation and withdraw the appeal request. Customers, who contact Cigna when they receive the decision notification that they did not authorize the party to appeal on their behalf and want the opportunity to appeal the issue, will be allowed their full appeal rights. If the Customer does not object to the representation, and authorizes the party to represent the Customer to the conclusion of the appeal process, the Customer will have exhausted his/her opportunity to appeal the same adverse determination in the future.

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For all customers who request language services, Cigna provides interpretation (oral) or translation services (written) in the customer's preferred language to register an appeal and to notify customers about their appeal per Cigna policy.

Appeal Process

The Indiana Appeals Policy consists of a two-level (Indiana resolution of grievances and appeals of grievance decision) internal appeals process for group plans for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits. Examples include: any request to overturn a previous denial for prior-authorization of a health care service or supply if prior-authorization is required by benefit plan terms (a "pre-service appeal"); or a request for reimbursement of the costs incurred for a health care service or supply ("post-service appeal").

For individual plans, Customers will only be required to complete one level of internal review before pursuing an external review. For individual plan Customers, the internal appeals process will include resolution of disputes regarding initial eligibility decisions for individuals.

For non-grandfathered group and individual plans, the internal appeals and external review process will include appeals based upon rescissions of coverage whether or not the rescission has an adverse effect on any particular benefit at the time.

If Cigna does not adhere to internal claim and appeals processes, Customer is deemed to have exhausted the process and can proceed to external review, if available, and pursue other remedies under the law as applicable.

The internal claim and appeal process will not be deemed exhausted if the violation was:

- De minimus;
- Non-prejudicial;
- Attributable to good cause of matters beyond the plan's or Cigna's control;
- In the context of an on-going good-faith exchange of information; and
- Not reflective of a pattern or practice of non-compliance.

If Cigna reduces or terminates approval for an ongoing course of treatment, before the end of the period of time or number of treatments previously approved, Customer will have continued coverage pending the outcome of an internal appeal or the end of the approved treatment period.

Additionally, the Customer is entitled, upon written request, to an explanation within 10 calendar days, of Cigna's basis for asserting that it meets the above standards so that the Customer can decide whether to seek immediate review. If the Customer requests immediate external review and is rejected by the IRO or court, the Customer has the right to resubmit to Cigna for an internal appeal.

General Complaints and Quality of Care/Quality of Service Complaints

Inquiries and complaints are researched by referencing internal resources to determine whether the issue can be immediately resolved. In some instances, there may have been a processing error and/or the system may have or need to be updated that will lead to the transaction being reprocessed. This prevents the Customer from having to follow any other steps to get the issue resolved (e.g. appeal). All Verbal Complaints will follow Cigna's National

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Inquiry and Complaint Policy. The specific procedures for reviewing, investigating and resolving a Customer complaint vary depending on the category and type of complaint, as follows:

- a) For Verbal General Complaints, the Member/Customer Service Department shall conduct the review and investigation in accordance with Cigna's National Inquiry and Complaint Policy.
- b) Written General complaints will be referred to the National Appeals Organization (NAO) for handling as an appeal.
- c) Quality of Service Complaints relating to Cigna participating Providers or facilities which cannot be immediately resolved but which require further investigation and action shall be forwarded to PSU-Provider Service Unit for resolution.
- d) Quality of Care Complaints relating to Cigna participating Providers or facilities will be reviewed and investigated by the Quality Management Hubs
- e) For Quality of Care or Quality of Service Complaints relating to non-participating Providers or facilities, the complainant will be referred to the State Medical Board. For privacy rights complaints, the complainant will be referred to the Department of Health and Human Services Office of Civil Rights.

The Cigna Privacy Office will investigate any violation of individual privacy rights or disagreement about a decision regarding access to individual confidential information.

Time Limit to File an Appeal Request

Indiana allows a Customer to request a Level One and Level Two appeal (Individual plans have one internal level of appeal and follow the Level Two process) at any time within one year from the date Cigna issued its last adverse benefit determination.

Timeframes for Acknowledgement of the Appeal

All turnaround times are based on day of receipt being day 0.

Level 1/Level 2 Administrative and Medical Necessity Pre and Post-Service appeal:
Within 3 business days of receipt

Should Cigna Designee be able to resolve the appeal within 3 business days, a decision letter is to be sent to the party initiating the appeal in lieu of the acknowledgement letter.

Timeframes for Resolution of the Appeal

All turnaround times are based on day of receipt being day 0.

Level 1/Level 2 Pre-Service appeals: Within 15 calendar days of receipt of appeal request for each level
Level 1/Level 2 Post Service appeal: Within 20 business days of receipt of appeal request for each level.

One 15-calendar day extension is allowed for each level of Pre-Service appeal or one 10 calendar day extension is allowed for each level of Post Service appeal if the extension is due to circumstances beyond the insures control:

- 1) Failure of a provider that is not a participating provider to provide with 15 days of the filing of the grievance information that is requested and necessary to adequately review and investigate the grievance.
- (2) Failure of an enrollee to provide additional information requested that is necessary to resolve the grievance within 15 days of the filing of the grievance.

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(Indiana statute requires the Level 2 review be resolved as quickly as possible, reflecting the clinical urgency of the situation and not later than 45 calendar days after receipt of appeal)

Level 1 (single level mandatory) expedited/urgent appeal: Within 48 hours of receipt of appeal

Level 2 (voluntary second level) expedited/urgent appeals*: Within 48 hours of receipt of appeal

*The expedited second level review is voluntary. No extensions are available for expedited/urgent appeals.

Notification Decision

Level 1/Level 2 Expedited/Urgent Care Appeal: (a) Oral – Same day as decision; (b) Written - Within 2 calendar days of decision.

Level 1 and Level 2 Pre-Service: Within 15 calendar days of receipt of appeal request (within 30 calendar days with extension);

Level 1 and Level 2 Post Service: Within 20 Business days of receipt of appeal request (within 20 business days plus 10 calendar days with extension).

Independent External Review

For non-grandfathered group and individual plans: If the Customer is still not satisfied following completion of the two-level internal appeals process (single level for customers in individual plans), the Customer or his/her representative has the option to submit the dispute for resolution (which is binding upon Cigna and the plan) by an independent external reviewer for appeals that involve medical judgment as determined by the external reviewer. Adverse determinations involving medical judgment include, but are not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, a determination, or that a treatment is experimental or investigational. Other determinations eligible for external review include a determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program, a determination of whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques, or a rescission of coverage whether or not the rescission has an adverse effect on any particular benefit at the time.

Appeal Reviewer Requirements

Cigna will ensure that all appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the decision.

Level One Administrative (non-covered/excluded plan benefits) appeal decisions are made by a non-Health Care Professional(s) who: (a) was not involved in any previous decision; and (b) is not a subordinate of the individual who rendered any previous decision on the issue. Expedited requests must be reviewed by a Physician Reviewer or designee to determine if criteria for processing in accelerated timeframes are met.

Level Two Administrative (non-covered/excluded plan benefits) appeal decisions are made by a committee of non-Health Care Professional(s) who: (a) was not involved in any previous decision; and (b) is not a subordinate of the individual who rendered any previous decision on the issue. Others who have a "need to know" may attend the

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Committee Meetings. The Customer and/or his/her representative may participate via conference call. Committee review is not available for Expedited Appeals.

Level One and all Expedited Medical Necessity appeal decisions are reviewed by Health Care Professional(s), or behavioral health care professional(s), not involved in any previous decision. The Health Care Professional cannot be the subordinate of the individual involved in any previous determination(s). Approval decisions can be made by a non-physician Health Care Professional, including a pharmacist. A Physician Reviewer must be responsible for all medical necessity denial decisions. The Physician Reviewer must: (a) hold an active unrestricted license to practice medicine in a state or territory of the United States; (b) be board certified in the same profession as the treating provider and in the same or a similar specialty which typically manages the medical condition, procedure, or treatment; (c) for each appeal case, reviewer must attest to having the scope of licensure or certification that typically manages the medical condition, procedure, treatment or issue under review; as well as current, relevant experience and/or knowledge to render a determination for the case under review; and (d) unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting an appeal or appeals consideration.

Level Two Medical Necessity appeals must be reviewed by a Committee consisting of at least three individuals, with the following qualifications: (a) one member must be a Physician Reviewer; (b) one member must be a nurse reviewer or behavioral health care professional; and (c) one member must be a non-clinical professional. Voting Committee members cannot have been involved in previous decisions nor can they be the subordinates of individuals involved in any previous decisions. Others who have a "need to know" may attend the Committee Meetings. The Customer and/or his/her representative may participate via conference call. Committee review is not available for Expedited Appeals. A Same or Similar Specialist opinion must be obtained for standard Level Two Medical Necessity appeals. This Same or Similar Specialist opinion is considered in the Committee decision. A Physician Reviewer must be responsible for all denial decisions by Committee.

Advance Notice of Committee Meeting

Pre-service and post-service – within 10 calendar days in advance of scheduled date of meeting.

Note: No committee review for expedited appeals.

Appeals Involving Denials Based on Medical Judgment

The policy applies to all benefit coverage related denials. However, to comply with regulatory and accreditation agency requirements, additional steps must be taken in situations when the Adverse Benefit Determination is based in whole or in part on a medical judgment with regard to whether a particular treatment, drug or item is experimental/investigational/unproven or not medically necessary. To reflect the additional requirements applicable to appeals involving denials based upon medical judgment, separate requirements are reflected below in this policy.

Receipt of Additional Information

Any additional information received after the determination notice is sent will be considered in the next appeal level. Cigna reserves the right to reverse a denial decision at any point in that next appeal level if warranted by new information, without completing all components (e.g., Level Two Appeal review or Same or Similar Specialist reviews) of the appeal process.

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Additional Information

For non-grandfathered plans, Cigna will provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by Cigna in connection with the claim. This evidence will be provided as soon as possible, automatically and without request, and sufficiently in advance of the date of the final notification to give the claimant a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the appeal period will be tolled and the new or additional information will be provided to the claimant. The claimant will be afforded the opportunity to review and address the new or additional information as part of the appeal. Any comments or information submitted by the claimant thereafter will be taken into account in making the final internal appeal decision. If the claimant fails to respond within the time period allotted, the appeal will proceed and a final internal appeal decision will be made based upon the available information.

For non-grandfathered plans, Cigna will provide to the claimant, free of charge, any new or additional rationale upon which an adverse determination is based as soon as possible and sufficiently in advance of the date of the final notification to give the claimant a reasonable opportunity to respond prior to that date. If the new or additional rationale is identified so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the appeal period will be tolled and the new or additional rationale will be provided to the claimant. The claimant will be afforded the opportunity to review and address the new or additional rationale as part of the appeal. Any comments or information submitted by the claimant thereafter will be taken into account in making the final internal appeal decision. If the claimant fails to respond within the time period allotted, the appeal will proceed and a final internal appeal decision will be made based upon the available information.

Definitions

Adverse Benefit Determination means any denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of utilization review, including failure to cover an item or service because it is determined to be experimental /investigational/unproven, not medically necessary or not a covered benefit or otherwise excluded. For non-grandfathered group and individual plans it also means a rescission of coverage whether or not the rescission has an adverse effect on any particular benefit at the time.

Appeal (see Grievance definition)

Benefit Denial means a denial of service that is specifically excluded from the Customer's benefits plan and includes verbal General Complaints and all written General Complaints. Also includes Written Quality of Care and Quality of Service Complaints.

Business Day means any day where Cigna is open for business operations. Such definition does not include any national holidays or days when operations are temporarily closed due to extenuating circumstances (e.g. inclement weather).

Cigna may refer to Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, their subsidiaries and affiliates including any of the Cigna HealthCare HMOs.

Complaint means an expression of dissatisfaction from a Customer (or the Customer's representative, or practitioner on the Customer's behalf) – orally or in writing, including, but not limited to, dissatisfaction with Plan administration, disenrollment issues, or the way Customer Service is provided, or quality of care or service from a medical health care professional or facility.

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Customer means an employee or dependent covered under a benefit plan. An agent or authorized representative (e.g. treating provider or facility) may act on the Customer's behalf in an appeal.

Expedited (a.k.a. Urgent Care) Level One Appeal means the process for a Customer to request orally or in writing the first formal level of review of a Benefit Denial or Adverse Benefit Determination that is to be made within an accelerated timeframe due to the need for urgent care. An Expedited Level One Appeal is available when (a) Customer's treating Provider believes that processing the appeal request under the pre-service standard timeframes might jeopardize life, health, or ability to regain maximum functionality; (b) Requested due to failure to authorize an admission or continuing inpatient hospital stay for a Customer who has received emergency services but has not been discharged from a facility or (c) Customer's treating Provider, with knowledge of the Customer's medical condition, believes that by processing the appeal request under the pre-service standard timeframes it would subject the Customer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited (a.k.a. Urgent Care) Voluntary Appeal means the voluntary process for a Customer to request orally or in writing for review of an adverse Expedited Level One Medical Necessity determination, or an adverse Level One Medical Necessity determination within an accelerated timeframe. An Expedited Level Two Appeal is available when (a) Customer's treating Provider believes that processing the appeal request under the pre-service standard timeframes might jeopardize life, health, or ability to regain maximum functionality; (b) Requested due to failure to authorize an admission or continuing inpatient hospital stay for a Customer who has received emergency services but has not been discharged from a facility or (c) Customer's treating Provider, with knowledge of the Customer's medical condition, believes that by processing the appeal request under the pre-service standard timeframes it would subject the Customer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Grandfathered plans, under ACA, are plans that had at least one individual enrolled in the plan on 3/23/2010 (the date the law was enacted). Grandfathered plan rules apply separately to each benefit plan. Federal regulations set forth requirements for a plan to maintain its grandfathered status. Upon renewal, a client must make the determination of whether or not the benefit plan(s) continue to meet the requirements for grandfather status.

Grievance is any dissatisfaction expressed by or on behalf of an enrollee of a HMO regarding the:

- o availability, delivery, appropriateness, or quality of health care services;
- o handling or payment of claims for health care services; or
- o matters pertaining to the contractual relationship between;
 - (AA) an enrollee and a HMO; or
 - (BB) a group or individual contract holder and a HMO;and for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction

Health Care Professional / Health Care Provider means any physician/dentist or other licensed practitioner, (may include a nurse, pharmacist, social worker, or psychologist), accredited, or certified to perform health/dental services.

Initial Medical Necessity Determination means an initial determination that specific health care services of covered medical benefits do or do not meet the medical necessity requirements of the applicable benefit plan, or are excluded as experimental/investigational/unproven.

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1. **Prior Authorization/Pre-certification** means a medical necessity determination that is made prior to the intended delivery of the inpatient or outpatient health care services or supplies under review or prior to the performance of any services.
2. **Concurrent Review** means a medical necessity determination that is made during the period when the health care services or supplies are being provided to a Customer including a) during inpatient, intensive outpatient or residential behavioral health, or b) during ongoing ambulatory care
3. **Retrospective Review** means a medical necessity determination of any service that has already been received by the Customer.

Level One (Administrative and Medical Necessity) & Other Appeal means the first formal level of review of a Benefit Denial or an Adverse Benefit Determination (e.g., medical necessity denial) or any expression of dissatisfaction expressed by the Customer or his/her representative for which there is a reasonable expectation that action will be taken to resolve the matter that is the subject of the dissatisfaction. The Customer or his/her representative initiates the process by requesting, either orally or in writing, a change in the initial adverse decision. For administrative appeals, the benefit denial decision to deny payment of a service or supply may be the result of the service not being covered in the Customer's benefit plan. For medical necessity appeals, the covered benefit did not meet the medical necessity criteria as determined by a Physician Reviewer or Dental Consultant. This includes appeals for cosmetic procedures, experimental treatments or access to out of network providers on the basis of medical necessity.

Level Two (Administrative and Medical Necessity) Appeal means the process for a Customer or his/her representative to request in writing or orally a change of an adverse Level One Appeal determination.

Physician Reviewer means a Cigna Healthcare Physician, including a Psychiatrist, who is responsible for reviewing and rendering a decision on the appeal request. In some instances, an addictionologist or psychologist may be used depending on the request and the credentials of the requestor.

Pre-service appeal means any appeal for a covered benefit when the benefit plan conditions receipt of the benefit on approval of the benefit in advance of obtaining medical care. Dental pre-treatments estimates and medical pre-determination reviews are not considered pre-service appeals, as these are voluntary processes.

Post-service appeal means a request to change an adverse determination for care or services that have already been received by the Customer.

Quality of Care means an expression of dissatisfaction regarding the quality of care provided by the health care professional or facility.

Quality of Service means an expression of dissatisfaction regarding the quality of service provided by the health care professional or facility.

Relevant document, record or other information means any document that was relied upon in making appeal decisions and was submitted, considered, or generated in course of making a determination.

Representative means a party that the Customer authorizes to initiate an appeal on their behalf.

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Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. It does not include a cancellation: (a) that has only a prospective effect; or (b) a retroactive cancellation that is the result of non-payment of premium/contributions. It is also not a rescission when the termination is done at the request of the Customer and the employee contribution is refunded.

Same or Similar Specialist (a.k.a. Clinical Peer) means:

Same specialty means a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal.

Similar specialty means to a practitioner who has experience treating the same problem as those in question in the appeal, in addition to experience treating similar complications to those problems.

Utilization Review means the processes and procedures through which Medical Necessity determinations are made and appeals of Medical Necessity determinations are considered.

Procedure

A. Internal Reviews

1. **1st Level Standard (Written or Oral) Pre-Service or Post Service administrative or medical necessity appeal (for Individual plans, only one level of appeal is permitted and will follow the 2nd level appeal procedure):**

- The standard administrative and medical necessity appeal process is initiated upon receipt of an appeal request. An appeal request may be made orally or in writing. The following parties may submit an appeal: (a) the Customer; or (b) any party authorized to submit an appeal on behalf of the Customer, including the attending physician, ordering provider, facility rendering the service, or the claims payor. Cigna Designee enters the appeal request in the Appeals Processing System. The file will include: (a) the written or oral appeal request from the submitter of the appeal; (b) the appeal issue; (c) dates of service, if applicable; (d) procedure, service, practitioner/facility/provider rendering the service; and (e) any documentation and information submitted with the request.
- Cigna Designee sends written acknowledgement letter to Customer and his/her representative (if representative initiated the request) within three business days. Acknowledgement letter includes a description of the internal appeals process. For appeals filed by a party on behalf of the Customer, the acknowledgement letter to the Customer will request the Customer to immediately notify Cigna if the Customer has not authorized the party to represent him/her in the appeal process and whether the appeal request is to be withdrawn. Should Cigna Designee be able to resolve the appeal within 3 business days, a decision letter is to be sent to the party initiating the appeal in lieu of the acknowledgement letter.
- When a party is appealing on behalf of the Customer, the Customer must be aware of and have provided authorization for the representation. The acknowledgement letter will provide this opportunity as well as explain to the Customer the effect this decision will have on future appeal opportunities for this subject. The exception is for Expedited/Urgent Care appeals where the treating physician appealing on behalf of the Customer is always considered an authorized representative.

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- The Customer may contact Cigna to notify them that the party appealing on their behalf does not have authorization and to withdraw the appeal. The Customer's appeal rights will be retained. A withdrawal letter will be sent to the Customer confirming the withdrawal request.
- All relevant documentation (e.g. medical necessity criteria, benefit coverage criteria) that was relied upon for the previous decision or that will be considered for the appeal decision must be obtained. This includes information from the Customer's benefit plan. Customer or another party on behalf of Customer may submit written comments, documents or other information relating to the appeal. If additional clinical notes and documentation are needed, an outreach call will be made to the Treating or Ordering provider. If additional information is not received by the time the decision is due, the file will be noted and the review will be conducted based on the information at hand. Cigna will conduct a full and fair review of the substance of the appeal request, including any aspects of clinical care involved.
- If additional time is needed to obtain additional information or documentation, Cigna requests an extension from the Customer or his/her authorized party. Extension will only be allowed if the Customer or his/her authorized party agree to the request.
- For administrative (e.g., benefit exclusions and claim processing issues) appeals, the decision maker may be a non-clinician who was not involved in any previous decision on the issue. However, the decision maker may not be the subordinate of a previous decision maker.
- All medical necessity appeals will be reviewed by a Health Care Professional. Medical necessity appeals that can not be approved by a Nurse Reviewer or a behavioral health care professional will be reviewed by a Medical Director who: (a) is a Same or Similar Specialist; (b) was not involved with any previous decision; and (c) is not the subordinate of a previous decision maker.
- Resolution is recorded in Appeals Processing System. Any approval decisions are implemented within 15 calendar days of decision. Appeal record is closed within 5 business days of the date the required action was taken.

2. 2nd Level Standard (Written or Oral) Pre-Service or Post-Service Administrative and Medical Necessity Appeal (Single level for Individual plans):

- The 2nd Level Administrative or Medical Necessity Appeal process is initiated upon receipt of a request for a 2nd Level review of the 1st Level Appeal determination. The following parties may submit an appeal:
 - The Customer or any party authorized to submit an appeal on behalf of the Customer, including the attending physician, ordering provider, facility rendering service, claims payer.
- Cigna Designee enters the appeal request in the Appeals Processing System. The file will include: (a) the written or oral appeal request from the submitter of the appeal; (b) the appeal issue; (c) dates of service, if applicable; (d) procedure, service, practitioner/facility/provider rendering the service; and (e) any documentation and information submitted with the request.
- Cigna Designee sends written acknowledgement letter to Customer and his/her representative (if representative initiated the request). Acknowledgement letter includes a description of the internal appeals process and requests that any pertinent documentation be forwarded to Cigna Designee within 3 business days, as well as a description of the internal appeal process. Letter also includes name, address and telephone of appeal coordinator, and statement of rights to request and receive all information relevant to the case, to attend hearing and submit supporting materials before or at

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the hearing and ask questions of any member of the review panel, and to be assisted or represented by a person of his choice. If committee meeting date/time is known at time of receipt of Level Two Administrative & Other Grievance, may send combined acknowledgement/appeals committee notification letter.

- For appeals filed by a party on behalf of the Customer, the acknowledgement letter to the Customer will request the Customer to immediately notify Cigna if the Customer has not authorized the party to represent him/her in the appeal process and whether the appeal request is to be withdrawn.
- When a party is appealing on behalf of the Customer, the Customer must be aware of and have provided authorization for the representation. The acknowledgement letter will provide this opportunity as well as explain to the Customer the effect this decision will have on future appeal opportunities for this subject. The exception is for Expedited/Urgent Care appeals where the treating physician appealing on behalf of the Customer is always considered an authorized representative.
- The Customer may contact Cigna to notify them that the party appealing on their behalf does not have authorization and to withdraw the appeal. The Customer's appeal rights will be retained. A withdrawal letter will be sent to the Customer confirming the withdrawal request.
- All relevant documentation (e.g. medical necessity criteria, benefit coverage criteria) that was relied upon for the previous decision or that will be considered for the appeal decision must be obtained. This includes information from the Customer's benefit plan. Customer or another party on behalf of Customer may submit written comments, documents or other information relating to the appeal. If additional clinical notes and documentation are needed, an outreach call will be made to the Treating or Ordering provider. If additional information is not received by the time the decision is due, the file will be noted and the review will be conducted based on the information at hand. Cigna will conduct a full and fair review of the substance of the appeal request, including any aspects of clinical care involved. The Appeals Committee Coordinator prepares a chronological file for review.
- For non-grandfathered plans, in the event that any new or additional evidence is considered, relied upon, or generated by Cigna in connection with the appeal, we will provide a copy free of charge to the Customer, automatically, without request, and give them reasonable time to review prior to making the appeal decision. The Customer may request a stay of the appeal to allow time to consider the new evidence and respond to it. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the appeal period will be tolled and the new or additional information will be provided to the claimant. The claimant will be afforded the opportunity to review and address the new or additional information as part of the appeal. Any comments or information submitted by the claimant thereafter will be taken into account in making the final internal appeal decision. If the claimant fails to respond within the time period allotted, the appeal will proceed and a final internal appeal decision will be made based upon the available information.
- If additional time is needed to obtain additional information or documentation, Cigna requests an extension from the Customer or his/her authorized party agree to the request.
- For Administrative (e.g., benefit exclusions and claim processing issues) appeals are resolved by a Committee consisting of a minimum of three (3) persons, none of whom were involved at any previous level of the case nor were subordinates of those responsible for previous decisions. The

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Committee members must include: one person that may be an uninvolved Customer or an uninvolved Cigna employee and a Physician Reviewer may attend, if necessary.

- Medical necessity appeals are resolved by a Committee consisting of a Physician Reviewer, Nurse Reviewer or a behavioral health care professional and a non-clinician voting member. The appeal must be reviewed by a different Same or Similar Specialist than the Same or Similar Specialist who reviewed the Level One appeal. The Same or Similar Specialist may attend the Committee meeting to present his/her recommendation or submit his/her recommendation to the Committee in writing. The Customer, the party appealing on their behalf, the treating provider and/or any other party authorized by the Customer has an opportunity to present their appeal to the Committee via teleconference. If the Customer notifies Cigna that a lawyer will represent him/her, Cigna Legal Division must be notified the same business day that the notification is received. The Customer will be notified at least ten (10) days prior to the Committee meeting as to the date, time and how to participate. The Customer will be contacted orally within one (1) calendar day following the Committee meeting with the Committee's decision. Written notification of the decision will be generated within 24 hours of the Committee meeting.
- There is no need for a Committee Meeting if approval decision can be made prior to Committee meeting. In the case of Medical Necessity appeal reviews, there is no need to obtain a Same or Similar Specialist review opinion.
- Resolution is recorded in Appeals Processing System. Any approval decisions are implemented within 15 calendar days of decision. Appeal record is closed within 5 business days of the date the required action was taken.

3. Expedited: Level One or Level Two (Written or Oral) Appeal

Only Pre-Service reviews are eligible for expedited processing. The second level expedited/urgent appeal review is voluntary and is only available following the conclusion of the Level One expedited/urgent review. There is no committee review for second level expedited/urgent appeals.

- The Customer, the Customer's Provider, or a party appealing on behalf of the Customer may submit an oral or written expedited/urgent care appeal request. For oral appeal requests, the Cigna designee will record receipt date and the issue into the system/file on behalf of the Customer and review their understanding of the appeal issue.
- Cigna Designee enters the appeal request in the Appeals Processing System. A Cigna HealthCare Professional will determine if the appeal meets the criteria for processing as an expedited/urgent appeal as noted in the definition section of this policy. An outreach call to the treating provider may be made if clarification or additional information is needed.
- If the appeal does not meet the criteria for expedited/urgent processing, the Customer, the Customer's treating provider and/or his/her authorized representative will be notified by phone that the appeal will be processed as a standard pre-service appeal.
- If the appeal involves a denial of coverage for ongoing treatment previously approved, the Customer is entitled to a simultaneous external review in advance of the reduction or termination in coverage.
- The Customer may contact Cigna to notify them that the party appealing on their behalf does not have authorization and to withdraw the appeal. The Customer's appeal rights will be retained. A withdrawal letter will be sent to the Customer confirming the withdrawal request.

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- No extension is available. The decision must be based on the information available within the designated 72 hours.
- For non-grandfathered plans, in the event that any new or additional evidence considered, relied upon, or generated by Cigna in connection with the appeal, we will provide a copy free of charge to the Customer automatically without request, and give them reasonable time to review prior to making the appeal decision. The Customer may request a stay of the appeal to allow time to consider the new evidence and respond to it. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the appeal period will be tolled and the new or additional information will be provided to the claimant. The claimant will be afforded the opportunity to review and address the new or additional information as part of the appeal. Any comments or information submitted by the claimant thereafter will be taken into account in making the final internal appeal decision. If the claimant fails to respond within the time period allotted, the appeal will proceed and a final internal appeal decision will be made based upon the available information.
- All relevant documentation (e.g. medical necessity criteria, benefit coverage criteria) that was relied upon for the previous decision or that will be considered for the appeal decision must be obtained. This includes information from the Customer's benefit plan. Cigna will conduct a full and fair review of the appeal request.
- Decision is communicated orally to the Customer or party appealing on behalf of Customer, including the Customer's treating provider.
- A decision letter is mailed within two calendar days of oral communication. Customer is notified that the second level expedited appeal is voluntary and not required prior to pursuing an external independent review for medical necessity or legal action under Section 502(a) of ERISA.
- Resolution is recorded in Appeals Processing System. Any approval decisions are implemented within 15 calendar days of decision. Appeal record is closed within 5 business days of the date the required action is taken.

4. Decision Letters

- Written notification for all appeal decisions will be issued to the Customer or party authorized to appeal on behalf of the Customer or the appellant if the appellant is other than the Customer. For Medical Necessity appeals, a copy will be sent to the attending physician or other ordering provider or facility rendering service.
- All Decision letters will identify the decision maker(s) and any other reviewers of the appeal request. Cigna issued Decision letters will identify the title and qualifications of all decision makers associated with an appeal request. The physician reviewer's full name will be displayed, but the administrative and nurse reviewers will be identified using their first name and first initial of their last name. Cigna's internal files will identify the physician reviewer, nurse and administrative reviewer's full name. Overturn (approval) decision letters must include the approval decision date.
- If decision notification letter (e.g., Approval or Denial) is sent by facsimile, it is unnecessary to send the same letter by mail.
- For non-grandfathered plans, for plan years beginning on or after 9/23/10, all adverse determination notices will include information sufficient to identify the claim involved. Notices will include information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS ACT Section 2793.

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- For non-grandfathered plans, for plan years beginning on or after 1/1/12, adverse determination notices will include a statement regarding the availability of language assistance services.
- Upheld (denial) decision letters must be sent to the Customer and his/her representative and must include:
 - a) a summary of the issue to illustrate understanding of the facts of the case;
 - b) the decision and rationale in clear terms (principle reasons for the determination);
 - c) reference to the language in the GSA, certificate or summary plan description on which the decision is based. Exact quotes when appropriate;
 - d) a statement that the Customer is entitled to receive free access to, and copies of, all documents, records and other information pertinent to the appeal for benefits.
 - e) The name of the specific rule, guideline, or protocol relied upon.
 - f) A description of the additional appeal rights, if applicable, including a statement of the Customer's right to bring legal action under Section 502(a) of ERISA, if Customer covered by ERISA;
 - g) If applicable, notice of the Customer's right to submit a complaint to the state regulator(s), including specific ERISA disclosure language,
 - h) A list of the names, titles and credentials/board certifications of the individuals participating in the Committee review of the appeal, if applicable.
 - i) for plan years beginning on and after 1/1/12, notice of opportunity to request specific diagnosis and treatment codes submitted by Provider and their meaning; and
 - j) for plan years beginning on and after 1/1/12, notice of the availability of oral translation services, as required under federal law.

For Medical Necessity Appeals, the following is required:

- k) Statement that the scientific or clinical judgment explanation that was relied upon for the determination will be available upon request.

Appeal documentation will include:

- 1) Name and credentials/credential of the clinical peer completing the appeal review/decision.
- 2) Name of the patient, provider and/or facility rendering service.
- 3) Minutes or transcripts of any committee meeting
- 4) Date of an appeal review, documentation of action taken, and final resolution.

5. Medical Necessity Same or Similar Specialty Requirements

- A Medical Director of same or similar specialty must be responsible for all denial appeal decisions that can not be approved by a Nurse Reviewer or a behavioral health care professional. The Medical Director must not be involved in the initial decision or be the subordinate of the individual involved in the initial determination.
- Identification of a Same or Similar Specialist
The following must be considered when determining the appropriate physician specialty match:
 - The specialty of the physician ordering the service
 - The specialty of the physician requesting the appeal
 - The specialty of the physician rendering the care or service
 - The service/care being reviewed for consideration on appeal
 - Based on an evaluation of the above, make the 'closest' specialty match possible.

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6. If additional appeal requests are received after all internal and any applicable external review options are exhausted, the Appeal Coordinator asks the appealing entity to forward the request to the appropriate party (employer/plan sponsor/plan administrator) for further review and consideration.

7. If requested in writing, within one year of the previous determination decision, Cigna must provide, free of charge, reasonable access to or copies of all relevant documents, records, or other information pertinent to the appeal determination.

- Cigna will follow Confidentiality Policy requirements and workflows for providing copies of all relevant documents from the appeals file. Requests that include an authorization or consent form signed by the Customer authorizing release of the relevant documents to a party other than the Customer will be processed and sent to the Customers' Authorized Representative.
- The documents will include, but not be limited to, relevant pages from benefit booklet; criteria/guidelines relied upon or relevant to the claim decision; all clinical records obtained from Customer/provider and related resources (e.g. Journals, articles, research material); Nurse/Physician Reviewer notes that were created and/or relied upon as part of the coverage decision; Same or Similar Specialist Reviewer recommendation relied upon for decision.
- The relevant document(s) will be sent to the Customer, or their Authorized Representative with a cover letter, within 30 calendar days of receipt of request. This correspondence will be retained in the appeal file.

B. External Reviews

- **Third Level/External Written or Oral Review (Optional per Jurisdictional/Account Specifics) Appeal:**
A 3rd level review is conducted by an external independent review entity. For individual plans, Customers will only be required to complete one level of internal review before pursuing an external review. Any state-specific and accreditation mandates related to this process are followed. Customers are notified of the program annually. The Customer or their authorized party is informed in the Level 2 denial letter of their right to an external review and the eligibility criteria for the external review.
- Adverse determinations involving medical judgment include, but are not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, a determination, or that a treatment is experimental or investigational. Other determinations eligible for external review include a determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program, a determination of whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques, or a rescission of coverage whether or not the rescission has an adverse effect on any particular benefit at the time.
- They are informed that the process allows them to submit additional information. At the time Cigna receives their request for an external review, they will be send a letter outlining the process, noting that there is no interference by Cigna in the review, reiterating again that the Customer bears no cost for the review, and how a representative may submit the external review request on behalf of the Customer. The Customer will be required to complete an election form for the review. Cigna confirms in writing, when the file has been forwarded to the external independent review entity. The determination of this appeal review is final and binding upon Cigna and is communicated to the Customer. Cost of the appeal review is the responsibility of Cigna, not the Customer.

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EXTERNAL REVIEW PROGRAM:

- Customer and/or representative and/or provider on their behalf receives Level Two Medical Necessity or Expedited Level Two Medical Necessity denial and determines that they want to pursue an external review of such issue. Issue must involve: (1) an adverse utilization review determination, (2) an adverse determination of medical necessity, or (3) a determination that a proposed service is experimental or investigational. Within 120 calendar days after receipt of adverse Level Two Medical Necessity or Expedited Level Two Medical Necessity decision, sends written request for external review of issue to the Healthplan no later than 120 calendar days after receipt of adverse Level two Medical Necessity or Expedited Level Two Medical Necessity decision. Customers are limited to one external review per issue.
- The Healthplan selects an IRO (which does not have any material professional, familial, financial, or other affiliation with any parties involved) from a list certified by and provided by the Indiana Department of Insurance. (Must rotate through entire list of IROs provided before repeating a selection, see link: <https://www.in.gov/idoi/2567.htm>)
- If, at any time during the external review process, the Customer submits additional information which may impact the Healthplan's decision, the Healthplan shall reconsider its decision within 15 calendar days after the date of receipt of such information. During this Healthplan reconsideration period, the external review shall cease, but may resume upon the Customer/representative's request if the Healthplan continues to uphold its denial after review of such information.
- Receipt of Additional Information: Upon receipt of any information submitted by the Customer, the assigned IRO must within one business day forward the information to Cigna. Upon receipt of any such information, Cigna may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by Cigna must not delay the external review. The external review may be terminated as a result of the reconsideration only if Cigna decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, Cigna must provide written notice of its decision to the Customer and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from Cigna.
- IRO requests relevant information from the Customer or representative, Healthplan, treating provider and any other relevant parties.
- IRO, within 15 business days from the Healthplan's receipt of external appeal, will make a determination based on information gathered applying:
 - the standards of decision making based on objective clinical evidence; and
 - the terms of the Customer's benefit contract.
- IRO, within 72 hours after making the determination, communicates decision to the Healthplan and Customer.

NOTE: An expedited external review is available if utilizing the above standard process would seriously jeopardize the Customer's: (a) life or health; or (b) ability to reach and maintain maximum function. If this situation occurs, the IRO will make a decision and notify the customer within 72 hours after the external appeal is filed with the Cigna. If, at any time during the external review process, the Customer submits additional information which may impact the the Healthplan's decision, and the issue still qualifies as an expedited issue, the Healthplan shall reconsider its decision within 72 hours after the date of receipt of such information. During this Healthplan reconsideration period, the external review shall cease, but may resume upon the

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Customer/representative's request if the Healthplan continues to uphold its denial after review of such information.

Cigna captures all IRO decisions within the automated appeals processing system. The IRO decision will be processed according to any timeframes specified by the IRO. This information is available to evaluate Cigna's medical necessity decision making process.

C. Record Retention

Cigna will maintain records for the longer of ten (10) years, or until the applicable State Insurance Commissioner has adopted a final report of an examination of the appeals register. Such records shall contain at a minimum:

- 1) a category generally describing the reason for appeal;
- 2) date received;
- 3) date of review;
- 4) resolution;
- 5) date of resolution(s);
- 6) name(s) of covered person(s), provider and/or facility rendering services;
- 7) description of information used to make decision;
- 8) name and credentials of person making the decision;
- 9) Reason/Root Cause of appeal; and
- 10) Copies of all correspondence from the patient, provider, or facility rendering the service.

D. Regulatory Reporting

Cigna Designee prepares reporting of appeals or complaints, according to state law. The report shall be prepared on a form provided by the Commissioner of Insurance (if applicable) and shall include:

- 1) A description of the appeals policy;
- 2) The total number of appeals handled through such system and a compilation of causes underlying the appeals; and
- 3) The number, amount and disposition of malpractice claims made by enrollees that were settled during the year.

In preparing the report for HMO business, the Cigna Designee (generally, the Healthplan Appeals Coordinator) will:

- 1) Decide whether to include FlexCare (Network) in the appeal totals, and
- 2) Take into account statutory definitions of "complaint," "grievance," and /or "appeal" in a given state, to ensure information is accurately reported.

Cigna Legal and Regulatory Compliance Organization may need to be consulted prior to providing a report to a regulatory agency by March 1st or a date established by the regulator.

HIPAA Applicable Policies & Procedures:

- HIPAA Corporate Policy: Use and Disclosure of Protected Health Information.
- Refer to HIPAA Corporate Policy: Safeguards: Physical, Technical and Administrative Safeguards.
- Refer to HIPAA Corporate Policy: Use and Disclosure - Minimum Necessary Use and Disclosure of Protected Health Information.

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- Refer to HIPAA Corporate Policy: Individual Rights – Restrictions on the Use and Disclosure of Protected Health Information.
- Refer to HIPAA Corporate Policy: Use and Disclosure of Protected Health Information.
- Refer to HIPAA Corporate Policy: Use and Disclosure - Minimum Necessary Use and Disclosure of Protected Health Information.
- Refer to HIPAA Corporate Policy: Use and Disclosure – Individual Rights, Confidential Communications.
- Refer to HIPAA Corporate Policy: Use and Disclosure – Business Associates.

Related Policies and Procedures/Resources:

Translation Policy and Guideline for Individual Communications Policy

Foreign Language Calls Policy

California (CA) Language Assistance Policy

Attachments: N/A

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